STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1920	A. BUILDING: _____ B. WING _____	C 09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NASHVILLE COMMUNITY CARE & REHABILITATION A	1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During complaint investigation of #39377, #39420, #39460 and #39479, conducted 8/16/16 - 9/1/16, at Nashville Community Care and Rehabilitation, no deficiences were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000		